Medical

Enrollment and Change Form

STEP #1

Check below to indicate plan enrollment

☐ Co-Pay Medical Plan ($20/$35 co-pay)

☐ Deductible Medical Plan ($300 deductible)

☐ I Decline Medical Coverage

STEP #2

Check appropriate options:

☐ New Enrollment Hire Date: _____

☐ Terminate Dependent Date_____ or Add Dependent Date: _____

☐ Open Enrollment
Change current medical coverage to:_____

☐ Qualifying Event Date: _____

☐ Marriage ☐ Divorce ☐ Birth ☐ Other_____

Enrollment due to a qualifying event requires proof validating the event

STEP #3

Complete Employee Information

☐ Board of Education School Employee

☐ County Government Employee

Indicate the Department or School Location where you work: _____

Work Phone: _____ Circle Home ***or*** Cell Phone: _____ Male or Female

Employee Name: _____ SS #: _____ Date of Birth: _____

Address: _____City: _____ State: ____ Zip: _____

***(PCP) Primary Care Physician First, M.I., & Last Name*:** _____

***PCP is only required for enrollment in Co-pay medical plan only**

STEP #4

Please list all family members to be enrolled or terminated

First, M.I., & Last Name (Please circle child or step-child)	SEX	Social Security #	Birth Date	*PCP required for Co-pay* option only PCP First, M.I., & Last Name
SP	F M	- -	- -	
CH Step-Ch	F M	- -	- -	
CH Step-Ch	F M	- -	- -	
CH Step-Ch	F M	- -	- -	

Enrollment of a spouse, the spousal form must accompany this enrollment form or spouse will not be added to insurance. Enrollment of a child between the age of 19-25, verification of student status must accompany this enrollment form or the child will not be added to insurance.

Step-Children MUST resides in your household & natural parent must remain married to you and also reside in your household.

STEP #5

By signing below, I agree to all terms and conditions of enrolling in and continued enrollment in the Williamson County Medical program, as such exist on the date of my enrollment as reflected below, and as such may change from time to time, with or without notice to me. I further represent and warrant that all information given by me is accurate, current and complete to the best of my knowledge. I agree to allow the Williamson County Benefits Department to have the appropriate deductions taken from my paycheck according to my above enrollment options.

Employee's Signature: _____ Date: _____

Williamson County Benefits Department use only: EE Hire Date: _____-_____-_____ Effect Date of Enrollment:_____-_____-_____